

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030184

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7821 STATE FILE NUMBER

FILED AUG 9 1963

VS 300
Rev. 4/59

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USE BLACK INK

OR

TYPEWRITER RIBBON

Banner

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN ST. LOUIS, MO.

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO.

b. COUNTY

c. CITY

OR TOWN

ST. LOUIS

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS

(If outside, give location)

928 NO. 17th St.

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First

BABY BOY

Middle

LEMOY

Last

LONDON

4. DATE OF DEATH

Month

Day

Year

7

3

63

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. Married ☐ Never Married ☒

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

7/2/63

9. AGE (last birthday)

IF UNDER 1 YEAR

Months Days

1 2

IF UNDER 24 HR

Hours Min.

2 22

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10b. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (City and state or country)

ST. LOUIS, MO.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

UNKNOWN

13b. MOTHER'S MAIDEN NAME

SARAH MAE LONDON

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

NO

(If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

ST. LOUIS CITY HOSP. #1.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Neonatal atelectasis

DUE TO (c)

762.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

Month, Day, Year

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐

NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

7-2-63

to

7-3-63

and last saw him

7-3-63

Death occurred at

7:40 P

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Corne E. Baxton, M.D.

22b. ADDRESS

1515 LAFAYETTE AVE.

22c. DATE SIGNED

7-3-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

JUL 31 1963

23c. NAME OF CEMETERY OR CREMATORY

Anatomical Board

23d. LOCATION (City, town, or county)

St. Louis, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Ogden 4106 Manchester

25. DATE RECD. BY LOCAL REG.

JUL 31 1963

26. REGISTRAR'S SIGNATURE

Robert Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.